Nassau - Queens PPS

PAC Meeting

December 4, 2014

Catholic Health Services of Long Island
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North Shore LIJ
North Shore-Long Island Jewish Health System

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Welcome and Introductions

Jerry Hirsch, Ph.D.
Vice President, Strategic Planning,
North Shore-LIJ Health System;
Assistant Professor, Hofstra North Shore-LIJ
School of Medicine

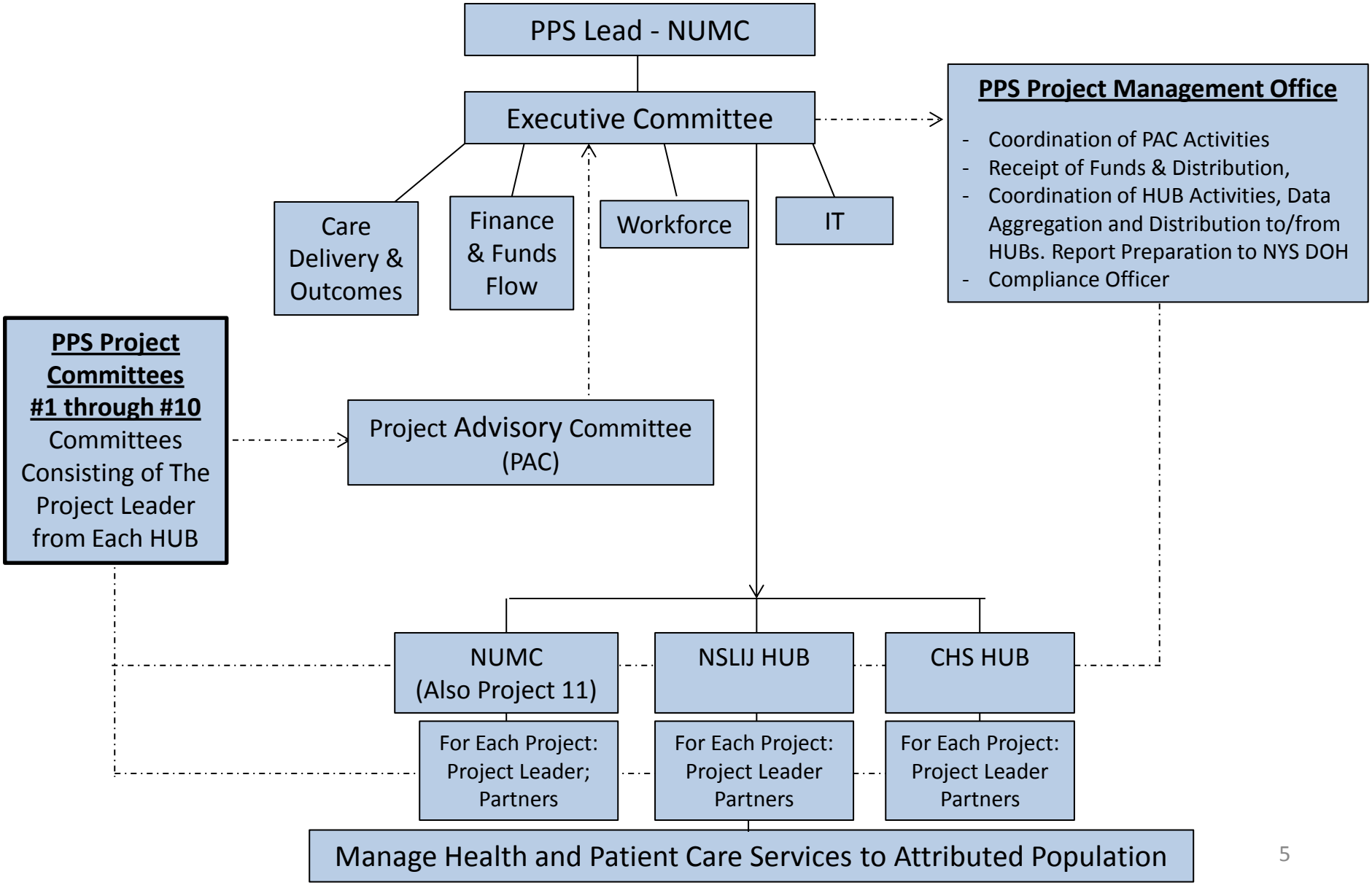
Accomplishments since 11/13 PAC Meeting

- Finalized Term Sheet as one PPS with NUMC as Lead
- Passed the Financial Stress Test
- Additional Rounds of Attribution – Final Attribution Submitted
- Draft application being written
  - ✓ 11 project application groups met twice
  - ✓ Draft application for each project written
  - ✓ Workforce, Finance and IT workgroups met and draft applications in progress

Nassau-Queens PPS Structure and Governance

Jeffrey C. Thrope
Partner, Health Care Industry Team
Foley & Lardner, LLP

Nassau-Queens PPS Governance Model



Status of the Selected DSRIP Projects

Kristofer Smith, MD
VP and Medical Director,
CareSolutions,
North Shore-LIJ Health System

2.a.i
Create an Integrated Delivery System

Summary	Resources in Place	Challenges	Resource Needs
• Ensure the health and well-being of community members based on their relationship with health care providers, as well as the spectrum of community-based organizations. • Ensure that individuals are connected to the most appropriate service setting, so as to avoid unnecessary and costly care. • Share appropriate information among providers in real time, while addressing cultural and linguistic needs.	• A robust network of providers, including medical, behavioral post-acute, long-term care, community-based providers, payers and social service organizations. • Most project partners have an EMR and are connected to the RHIO. • There are a number of Medical Health Homes in the Region. • PPS hubs have extensive experience managing high risk populations. • Experience transforming practices into PCMHs. • Cornerstone has a service delivery model for high risk behavioral health patients. • A strong network of culturally competent, community organizations	• Large population of uninsured who report challenges with access. • Fragmentation of care in the Nassau-Queens community • Ability to ensure that there are a sufficient number of employees trained to work in the outpatient and community setting. • Project coordination, so as to avoid multiple and overlapping programs. • IT integration and data sharing.	• Cross-facility training • Further enhance the Health Information Technology (HIT)-based coordination to insure full connectivity among members. • A repository of similar programs with centralized coordination. • Full PCHM Level 3 by year 3 for all participating PCPs • Integrated care management structure.

2.b.ii.
Co-location Primary Care Services in the Emergency Department (ED)

Summary	Resources in Place	Challenges	Resource Needs
• Accelerated triage in the ED and referral to the PCMH, to maximize the speed and impact of the co-located primary care model. • ED diversion will be implemented for those coming to the hospital due to non-acute conditions. • EMS workers will be empowered to assist in the triage of patients arriving via ambulance to divert those requiring primary care to the clinic.	• NUMC has already initiated construction of a primary care center next to it's ED. This will support achievement of an accelerated Level 3 PCMH status. • North Shore-LIJ has an algorithm-driven nurse triage hotline that provides symptom-based directions to the right level of care and experience using paramedics as physician extenders. • South Nassau has a treat and release model built into its ED which can be leveraged.	• Physical space constraints and lack of capital funds. • Risk of diverting patients who already have a primary care provider to a new hospital-based clinic. • Duplication of care delivery between the ED and the co-located primary care clinic. • Designing triage systems that comply with EMTALA. • Lack of provider continuity and poor handoffs resulting in poor implementation of treatment plants, preventable admissions and readmissions.	• Expansion of North Shore-LIJ triage hotline. • Development of EMTALA compliant referral protocols • Open access scheduling in primary are setting and HER/other technical platforms to track patients involved in this project. • A robust EMR for data analysis and reporting, plus staff training

2.b.iv. - Care Transition Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Summary	Resources in Place	Challenges	Resource Needs
• Identify an "accountable provider" for care transition. • Use a standard tool for proactive cross-system care planning via enhanced HIT. • Workforce will be retrained to be able to coordinate via electronically shared transition plans. • Transition case managers will visit with patients/families to develop a seamless plan and identify re-admission risks. • Non-health related factors will be addressed.	• PCMHs and outpatient embedded care managers across the PPS hubs • Paramedicine Transport PLUS model can be leveraged in cases where EMS is used to transport a patient home from the hospital. • Active health homes, intensive home care, home based primary care and local social service programs already in place that can be scaled and expanded to complement the project. • North Shore-LIJ eICU program • North Shore-LIJ helpline for after-hours nurse triage	• Transition planning efforts across the region have been challenged by weak communication infrastructure among providers. • Language and cultural barriers among patients. • Region's existing IT infrastructure is not presently operable to facilitate transitioning planning. • Repurposing hospital beds. • Respite care for patients with developmental disabilities, dementia and problem behaviors,	• Implement a standardized tool for cross-system care planning via enhanced HIT. • Workforce retraining for registered nurses, social workers, pharmacists, clerical staff and ED registrars to implement this enhanced model of care. • Standard care planning protocol • Data analytic implementation plan.

2.b.vii
Implement the INTERACT Project

Summary	Resources in Place	Challenges	Resource Needs
• Through widespread implementation of INTERACT SNFs will be able to reduce area hospitals' readmission rates. • Leverage experience in SNFs with transitional care programs and advanced care planning to improve readmission outcomes.	• Committee to identify champions for readmission prevention and address communication between SNFs and local EDs • Regional PPS INTERACT project workgroup • Several readmission prevention pilot programs • Care Connect model • Nurse practitioner model • Advanced care planning pilots. • Integration of hospice in some facilities.	• Historic independence of the region's SNFs. • Ensuring that hospitals understand what the SNFs are capable of providing at the sub-acute and acute care levels. • Off-hours clinicians and clinical infrastructure. • Workforce. • IT immaturity and poor connectivity	• Cross-facility training • Robust HIT-based coordination

2.d.i. - Implement Patient Activation of Activities for the Uninsured and Low/Non-Utilizing Medicaid Populations

Summary	Resources in Place	Challenges	Resource Needs
• All PPS partners will be informed about the project and their role in its successful implementation of PPS-wide outreach and patient activation as measured by PAM. • Members will be trained in how to use PAM. • Culturally competent outreach workers will conduct PAM screenings so high risk individuals can be identified. • Trained Navigators will be deployed with an array of interventions selected based on the identified need.	• A large existing public health workforce, as well as existing hospitals, EDs, FQHCs and peer and community outreach programs. • A strong network of community-based organizations, many of which already have existing relationships. • Health Homes that have already locate non-users and low-users via social media and other non-traditional methods. • NUMC Health Leads advocacy program • Rockaway Wellness Project	• Lack of health insurance is the most cited reason for not accessing care from a health provider in Nassau and Queens. • Lack of knowledge and connection to the health care system by this population exacerbated by language and cultural barriers. • Lack of available providers with capacity. • Coordination with other DSRIP projects. • Resource sharing and coordination.	• Cross-facility training. • Robust HIT-based coordination. • Project staff able to direct the initiative. • PAM trainers to conduct Train the Trainer dissemination • Bi-lingual and culturally competent health navigators. • Transportation network and/or money to pay for transportation.

3.a.i. – Integration of Primary Care and Behavioral Health Services

Summary	Resources in Place	Challenges	Resource Needs
• Engage the community and improve access to high quality patient-centered comprehensive care. • Implement primary care/behavioral health integration strategies along the continuum identified in the SAMHSA-HRSA framework. • Co-location of behavioral health services in Primary Care PCMH sites and co-locate primary care services in behavioral health programs.	• Long Island FQHC is actively recruiting behaviorists for its primary care settings. • Mercy's and Central Nassau Guidance Center's behavioral health programs are already embedding primary care services. • NUMC's outpatient psychiatry dept. and North Shore-LIJ's Behavioral Health Service line have programs where patient receive primary care during their behavioral health visit.	• Capital investments for developing appropriate medical facilities in behavioral health sites. • Insufficient psychiatry capacity. • Resistance by primary care physicians to addressing behavioral health issues. • Cultural competence and language barriers • Stigma associated with behavioral health issues. • Lack of patient compliance to treatment plans. • Lack of communication among providers and care coordination for shared patients. • Billing and operations issues.	• Non-MD behavioral health professionals to address shortages. • Telepsychiatry/ Enhanced IT. • Train providers, peer counselors and language interpreters • Care managers to ensure compliance with treatment plans. • A payer system which allows for same day multi-specialty billing.

3.a.ii. – Behavioral Health Community Crisis Stabilization Services

Summary	Resources in Place	Challenges	Resource Needs

• The PPS will establish a Community Crisis Clinical Leadership Team(CCCLT) to develop protocols and facilitate collaboration between providers and PPSs.
• Contracts with Medicaid MCOs will be pursued to develop sustainable funding.
• CCCLT will ensure that the IT systems developed and enhanced will facilitate necessary data sharing.
• The CCLT will also serve as a quality and utilization committee that will work to fill service gaps
	• The existing behavioral health crisis service system includes:
	  • Specialty psychiatric services in hospitals operated by all 3 hub providers.
	  • Inpatient detox beds at NUMC
	  • Mobile Crisis Teams (MCT) for children and adults
	  • 24/7 crisis hotline run by LI Crisis center.
		• Coordination and responsiveness problems with existing services.
		• Patients referred to ongoing care from hospital or ED fail to engage.
		• Crisis services are not accessible after hours and on weekends.
		• Lack of respite programs.
		• Transportation barriers.
		• Cost of capital/ infrastructure needs.
			• A walk-in behavioral health urgent care.
			• Enhanced MCTs
			• Expanded clinic hours
			• Care managers workforce
			• Regulatory changes needed to permit off-site clinical treatment services and telepsychiatry.
			• Medically and non-medically supervised transportation services.
			• Conversion of existing congregate residences into apartment treatment programs

3.b.i. – Evidence-Based Strategies for Disease Management in High Risk Adult Cardiovascular Patient Populations (Adults Only)

Summary	Resources in Place	Challenges	Resource Needs
• PPS will undertake evidence-based strategies to address cardiovascular disease. • All patients will be assigned a PCMH and enrolled in patient registries. • Care management software will be utilized to categorize patients by risk level. • Care management teams of nurses, navigators, care managers and pharmacists will closely follow patients. • Highest risk patients will be managed in home or in nursing homes.	• PPS hubs have highly regarded cardiac care and rehab programs. • NuHealth's "Transitions of Care" Program • NS-LIJ's outpatient EHR has disease registry components that can be expanded. • NS-LIJ's Center for Tobacco Control is a leader in tobacco dependence treatment. • High intensity home-based programs • Walgreens, a partner, does blood pressure screenings and medication therapy management.	• Integrating EHRs, particularly for physician practices. • Access of primary care physicians for timely follow-up appointments . • Medications reconciliation • Access to transportation. • Family and social issues, as well as health literacy make following treatment protocols challenging. • Pharmacists cannot bill Medicaid for MTM services.	• IT infrastructure for seamless interoperability • Remote monitoring devices • Telehealth to enable specialists to assist primary care providers. • Enhanced transportation service availability.

3.c.i. – Evidence-Based Strategies for Disease Management in High Risk Adult Diabetes Patient Populations (Adults Only)

Summary	Resources in Place	Challenges	Resource Needs
• PPS will undertake evidence-based strategies to address diabetes. • All patients will be assigned a PCMH and enrolled in patient registries. • Care management software will be utilized to categorize patients by risk level. • Care management teams of nurses, navigators, care managers and pharmacists will closely follow patients. • Highest risk patients will be managed in home or in nursing homes.	• CHSLI has outpatient diabetes education centers • NS-LIJ has numerous programs to address diabetes, including community outreach programs focusing on diabetes wellness. • NuHealth's Zoki Hossain Center for Hypertension, Diabetes and Cardiovascular Disease employs a multidisciplinary approach. • Bariatric Surgery programs and hyperbaric therapy are available throughout the PPS. • High intensity home-based programs	• Insufficient outpatient providers, including diabetes educators. • Ineffective weight loss programs • Food Deserts/lack of healthy food in many communities.	• Develop a larger outpatient workforce. • Regulatory relief that will allow home health aides to administer medication. • IT infrastructure for seamless interoperability. • Remote monitoring devices for patients. • Telehealth to enable specialists to assist primary care providers.

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4.a.iii. – Strengthen Mental Health and Substance Abuse Infrastructure Across Systems

Summary	Resources in Place	Challenges	Resource Needs
• Address mental health-related problems within the clinical practice setting • Health promotion and disease prevention programs (HPDP) address mental health poorly. • Two task forces – Children and adult. • Develop cross-systems partnerships for a holistic approach. • Public education programs to destigmatize mental illness/ educate about the dangers of prescription drugs.	• Strength-based parenting and coaching support, such as early childhood home visit programs, circle of security programs, positive parenting programs, Strengthening families programs. • School based wellness promotion programs. • Clinical information available through the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid	• The cost of care managers and consulting psychiatrists. • Training primary care doctors to screen for, identify and talk to patients about behavioral health.	• Telepsychiatry • Technologically enhanced web chat capability. • Regulatory relief for consolidation of services operated by article 28, 21 and 32 clinics. • Decrease billing complexity. • School-based behavioral health clinics. • Space in primary care sites that are implementing the IMPACT model. • Enhanced IT • Additional Psychiatrists and social workers.

4.b.i. – Promote Tobacco Use Cessation, Especially Among Low SES Populations and Those with Poor Mental Health

Summary	Resources in Place	Challenges	Resource Needs
• Establish smoke-free indoor and outdoor environments at all of our facilities. • Advocate for change in Medicaid reimbursement policies. • Advocate for coverage of smoking cessation meds. • Track referrals/utilization of the NYS smokers Quitline. • Peer-to-Peer Counseling. • Process and outcomes measures tracking.	• NYS Smokers' Quitline • Ten"Stop Smoking Programs" located throughout Nassau and Queens. • NYC DOHMH's Tobacco – Free Hospitals Campaign. • Public policy assets including NYS's Clean Indoor Air Act, the Adolescence Tobacco Use and Prevention Act. • Existing Community-Based Organizations.	• Staff in FQHCs and OMH/OASAS funded programs may be averse to tobacco training. • Medicaid benefits that limit clinician reimbursement . • Health literacy issues related to education materials. • Engaging low SES people.	• All PPS members will need to have EHRs that prompt and track the 5 A's. • Presentation equipment. • Expanded Medicaid Coverage for smoking cessation initiatives.

Nassau-Queens PPS Website

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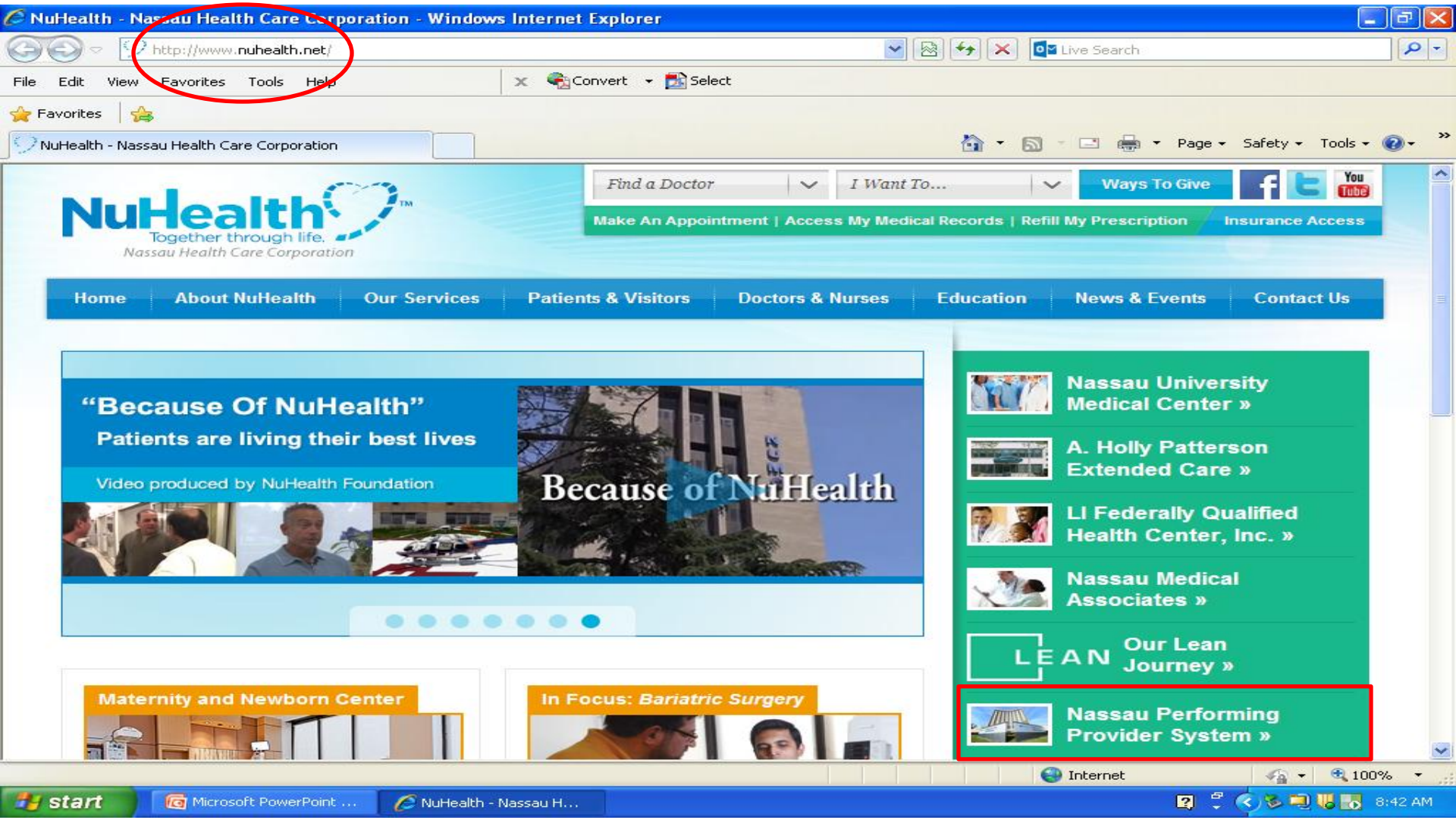
http://www.nuhealth.net/dsrip/

Nassau-Queens PPS Website



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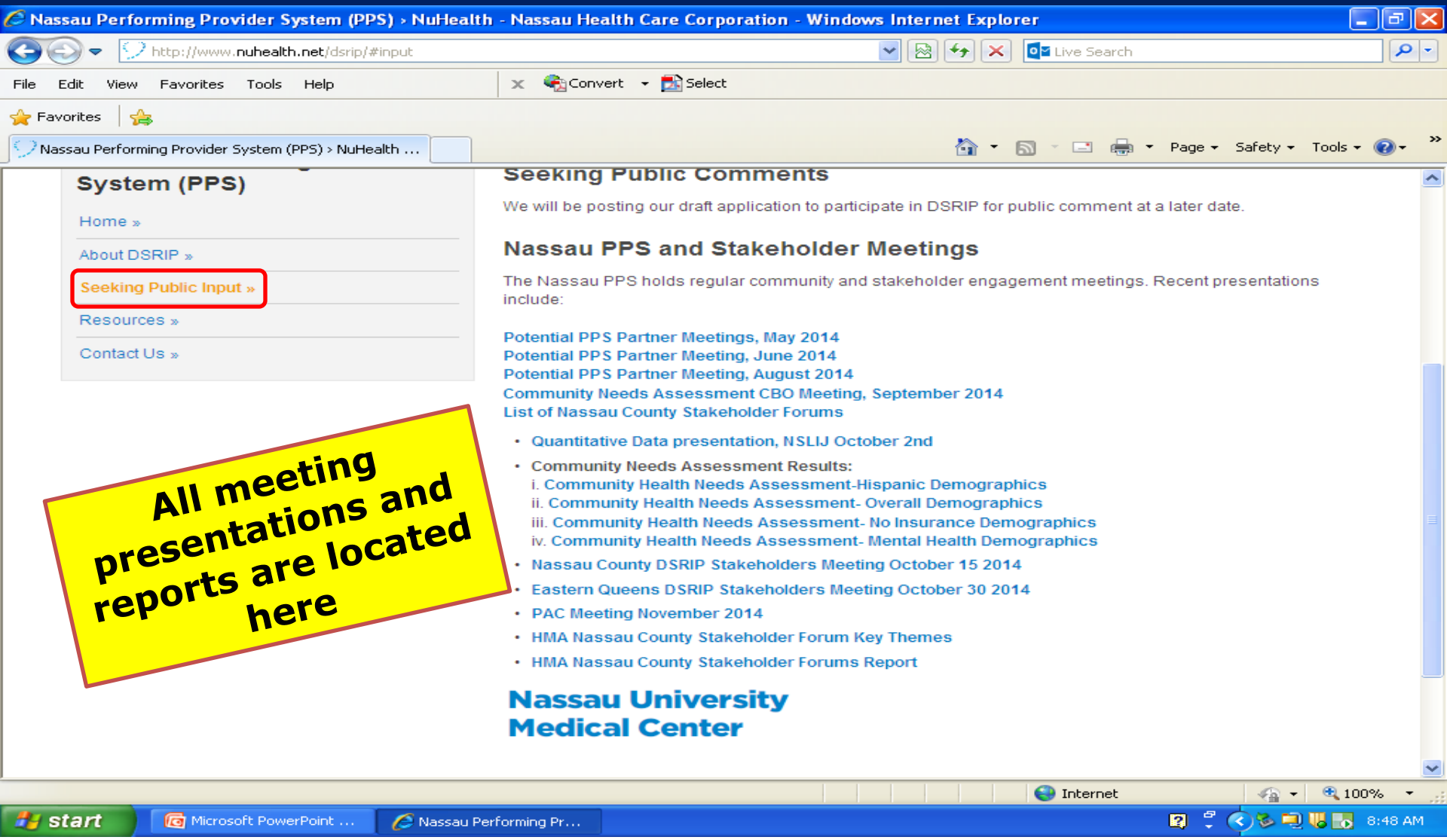
PPS Website Resources



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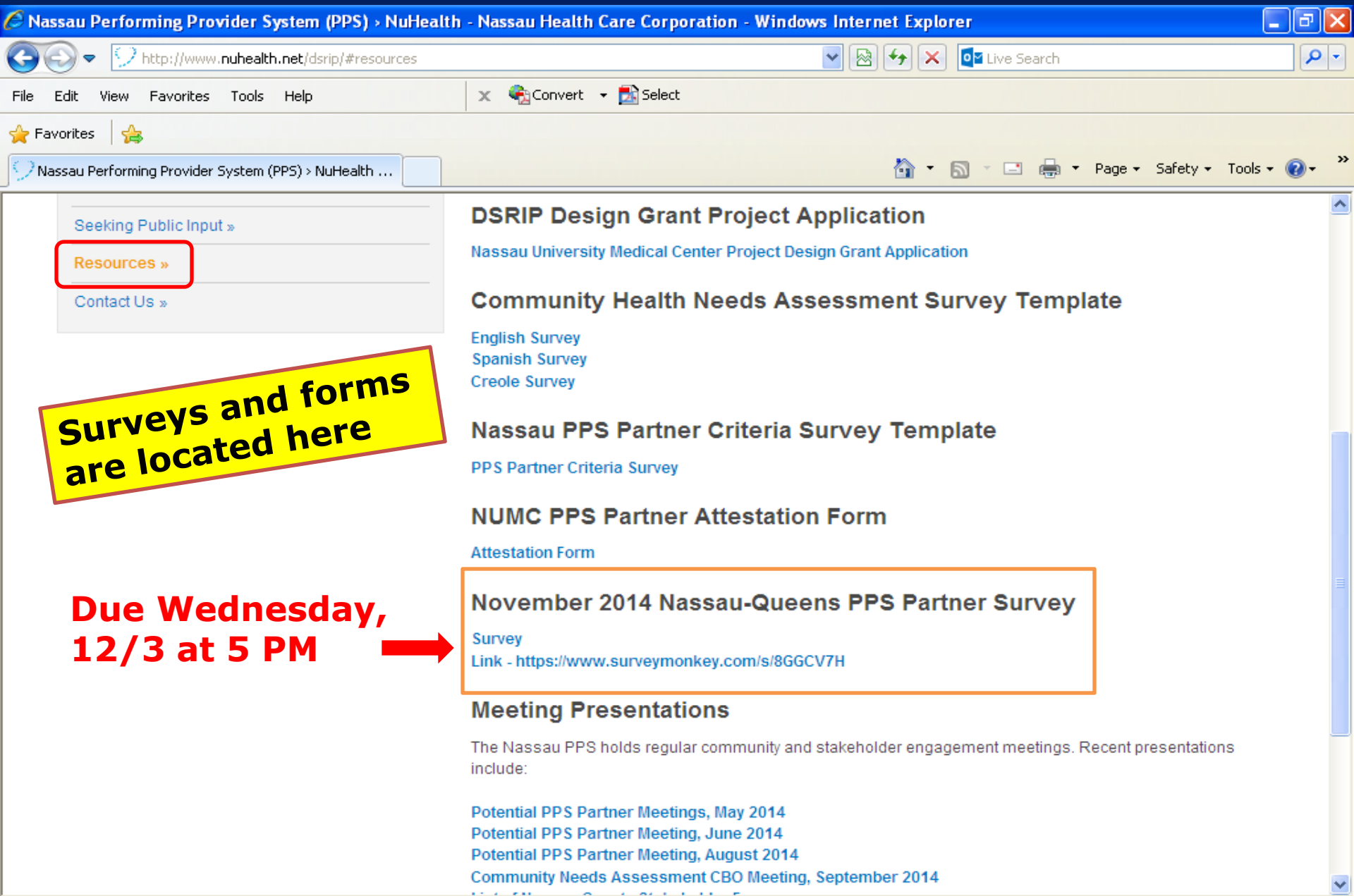

Next Steps

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DSRIP Timeline